JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UN-FACILITATED RESPONSE

TO HIV/AIDS, STD AND DRUG USE IN CENTRAL ASIAN COUNTRIES (KAZAKHSTAN, KYRGYZSTAN, TAJIKISTAN, TURKMENISTAN AND UZBEKISTAN)

1996-1998

UNAIDS

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ACRONYMS AND ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
CAR	Central Asian Republics
CBO	community based organisation
CCEE	countries of Central and Eastern Europe
CIS	Commonwealth of Independent States
CSW	commercial sex worker
FP	family planning
GDP	gross domestic product
HIV	human immunodeficiency virus
HLD	healthy lifestyle development
ICPA	inter-country programme adviser
IDU	injecting drug user
IEC	information, education, communication
IMR	infant mortality rate
KAPB	knowledge, attitude, practices, behaviour
MCH	maternal and child health
MSM	males who have sex with males
NGO	non-government organisation
NIS	Newly Independent States
Ob/Gyn	obstetrics/gynaecology
PLHA	people living with HIV/AIDS
RAR	rapid assessment and response
RH	reproductive health
STD	sexually transmitted disease
TB	tuberculosis
ToT	training of trainers
UNAIDS	Joint UN Programme on HIV/AIDS
UNDCP	UN Drug Control Programme
UNDP	UN Development Programme
UNESCO	UN Education, Science and Culture Organisation
UNFPA	UN Population Fund
UNICEF	UN International Children Emergency Fund
WHO	World Health Organisation

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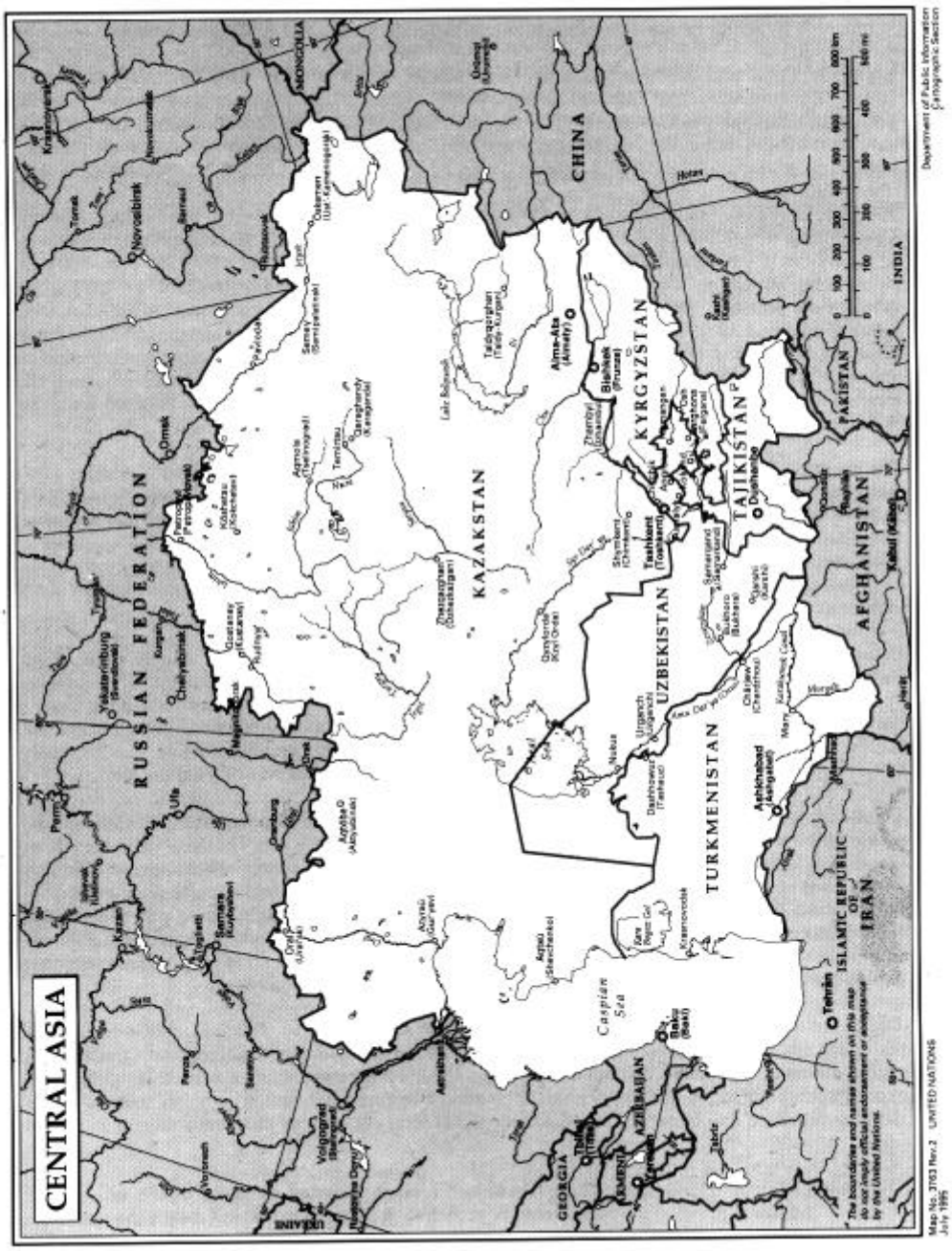


EXECUTIVE SUMMARY

Purpose

The purpose of this report is to share information about the status and trends of HIV/AIDS, STD and drug use spread in Central Asian region in the socio-economic context of continuing transition, to give overview of UNAIDS-catalysed assistance at country- and inter-country level, and to analyse the way the response has been evolving in CAR during the last three years.

Socio-economic context

The economic dislocation in Central Asian countries at the rupture of the USSR has led to a number of consequences associated with increased risk of HIV, STD and drug abuse spread: CAR see economic hardship and rise in poverty, increased pressures on social sectors, high mobility of population, decline in health of the people, changes in lifestyles and familial relations. Young structure of populations is another feature of the sub-region that has clear implications in the HIV/AIDS context.

Risk and vulnerability: situation with HIV/AIDS, STD and drug use

Though, in general, Central Asian sub-region has been very slightly touched by HIV, Kazakhstan faces localised HIV outbreak among IDU in Northern part of the country since mid-1996. Strikingly high STD rates and rapidly growing drug use in CAR are key signals of the potential for HIV infection growth in the sub-region. Vulnerable groups including MSM, IDU and CSW are at particular risk of HIV acquisition.

Main directions of UNAIDS-catalysed assistance

UN Theme Groups in CAR relatively quickly moved from initial set-up and information exchange stage to establishing a close dialogue with Governments and then to more coordinated action focusing on advocacy, programme frameworks development and resource mobilisation. Though some partnerships are formed and gain strength, participation of co-sponsors remains uneven. New opportunities for more effective assistance are now opened up by the emergence of multi-track cooperation programmes in all CAR and need to be used.

Progress in countries' response to date

Response to HIV/AIDS, STD and drug use problems in Central Asia has significantly advanced over the span of last years and is characterised now by a new level of understanding by Governments, NGOs and other national partners of the threat posed by these problems. This understanding is marked with considerably more attention that the preventive targets start to attain in official plans and policies, as well as with positive developments in legislative and regulatory environment for addressing HIV-related problems. The need for collaboration to cut across the sectors and to enable productive dialogue between central and local levels is recognised to far more extent, and mechanisms for coordination are being put in place. This

progress becomes increasingly reflected in re-orientation of practical actions. At the same time, the overall preparedness of countries to effectively confront HIV/AIDS or cope with STD and drug abuse spread remains sub-optimal. Given the continuing socio-economic difficulties of transition period, changes in lifestyles and existing gaps in skills and capacity for adequate preventive work, the challenge now is to build further on what has been successfully started, improve quality and sustain impact.

Upgraded agenda for HIV/AIDS sub-regional strategy

To a certain extent, the positive trends in countries' response are attributable to the development assistance catalysed by UNAIDS and supported by co-sponsors and other donor partners. Collaboration laid solid grounds for expanded response including higher commitment and motivation of leadership and strengthened technical capacity of those involved in practical preventive work. Cooperation programmes, though progressing in Central Asian countries with different speed and at different scale, give opportunities to test and adjust concepts and approaches and, thus, to form a body of knowledge and experience in countries and the sub-region adapted to local realities. The new and more advanced stage of UNAIDS-assisted cooperation calls for upgraded agenda for the sub-regional strategy. Its guiding principles are:

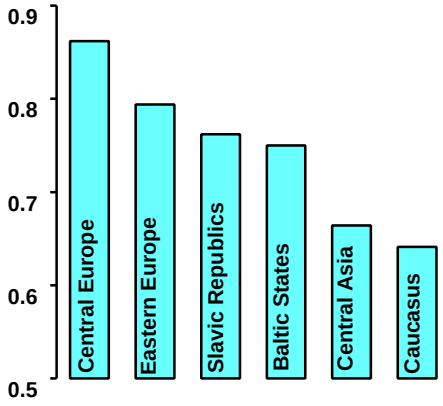
- *to follow further a phased approach at the sub-regional, national and local levels;*
- *to promote national ownership and responsibility over cooperation programmes;*
- *to broaden resource and support base for assistance;*
- *to increase reliance on the improved national and sub-regional technical expertise.*

1. SITUATION ANALYSIS

1.1 SOCIO-ECONOMIC FACTORS IN THE CONTEXT OF HIV/AIDS, STD AND DRUG USE SPREAD IN CENTRAL ASIA

The Central Asian Republics (CARs) vary in size, geography and natural resources - ranging from the desert of Turkmenistan to the lush vegetation of the Fergana valley and the snowy plateaux of the Tyan Shan and Pamir mountains. Although each republic is unique, they share a common Soviet inheritance and undergo the transformation that is accompanied with similar worrying trends in human development including high rates of poverty and rapidly growing economic and social inequality amounting to socio-economic fragmentation and deterioration in public health.

Fig. 1. Human Development Index, 1997



Source: UNDP (1998a)

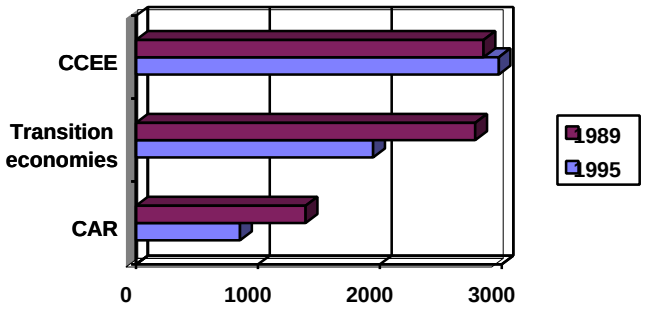
The 1997 Human Development Index, as average for CARs , has been lower than for any other sub-regional grouping of transition economies except for Caucasus (Fig.1).

Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan, like the other constituent republics of the former Soviet Union, acquired political independence at the end of 1991 as a result of the sudden and unexpected demise of the Union. The governments of the newly independent states were confronted, almost overnight, with the task of assuming direct responsibility for a huge range of administrative, economic, social and environmental problems. Some of these problems are shared by all the former Soviet republics. However, in Central Asia they are more acute because of the lower level of development and the more critically balanced social and environmental conditions. During the Soviet period these republics were to a large extent dependent on all-Union economic structures and on assistance from central government. Social services were largely funded by central government subsidies. Also, the high degree of specialisation in the production of raw materials had created lop-sided economies; this in turn caused a far higher degree of inter-republican trade than was to be found elsewhere in the Union. Post-1991, the abrupt cessation of central government subsidies and the dislocation of the all-Union supply, production and transportation systems, had a devastating effect on the newly independent Central Asian states as was seen in a dramatic **reduction in output** across the Central Asian region. In 1995 the GNP per capita, as average for CARs, has been less than half of the average for transition economies and less than one-third of the average for CCEE region (Fig. 2).

The pace of transition has not been consistent across the region. Kyrgyzstan and Kazakhstan experienced early price liberalisation with subsequent runaway inflation. Tajikistan has been

perhaps the slowest reformer and also suffered the greatest drop in output - largely the result of civil conflict for much of the period - whereas Uzbekistan, another slow reformer, has managed to avoid many of the large shocks associated with transition elsewhere in the region (Falkingham, 1998).

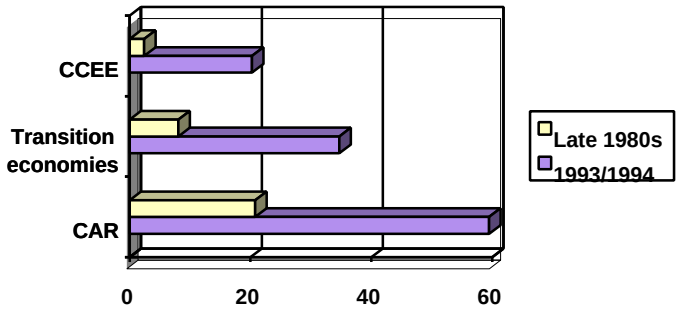
Fig. 2. GNP per capita, PPP (US$)



Source: UNDP (1998a)

The transition to a market economy did not originate **poverty** in the CARs (Fig.3), but it may have exacerbated the existing problem and given rise to new groups of poor. The Central Asian and Caucasus republics were the poorest in the USSR and the percentage of low-income households was highest in these republics (Pomfret, 1997). Within the USSR poverty was mainly a problem of large families, single pensioners or disadvantageous groups like disabled people. With the transition to a market-oriented economy, the distribution of income and wealth has become more unequal. The newly poor include unemployed, unpaid workers, and workers suffering from steep falls in real wages.

Fig. 3. Poverty: headcount index (% of population)



Source: UNDP (1998a)

A particular feature of the poverty in many CIS countries, including Central Asian republics, is the extreme poverty in so-called one-company towns where the entire labour force and social infrastructure were dependent on one or a few enterprises during Soviet times and which have since closed or severely suffered during transition. In Kazakhstan there are 50-60 company towns (with population around 150-200 thousand people in each). Residents of one-company towns face particular difficulties as local unemployment rates are extremely high, those still working are often subject to short hours or administrative leave and the prospects for alternative work are bleak. One-company towns are known for high crime rates and spread of self-destructive behaviour, especially among youth. One of those towns in Northern Kazakhstan, Temirtau, has become a site of a major HIV outbreak in Kazakhstan and Central Asia at large, mostly among injecting drug users.

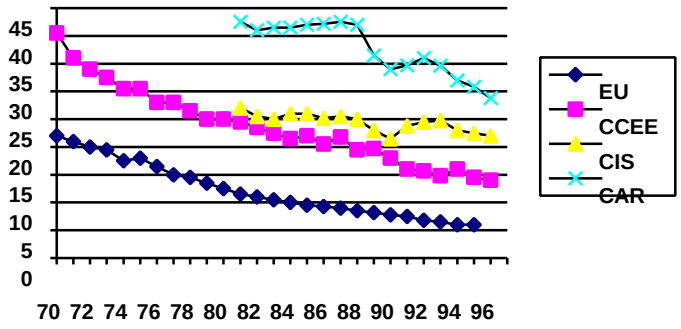
The increasing outlook for employment is a clear sign of the deteriorating economic conditions across the Central Asian region. The official **unemployment** rates are low (4.1%

in Kazakhstan, 4.4% in Kyrgyzstan, 2.4% in Tajikistan, 0.4% in Uzbekistan in 1996) (UNDP, 1998b) and do not reflect the extent of the problem. More important is the large volume of part-time work and involuntary leaves from jobs, most of which are unpaid. Others, discouraged by the lack of employment prospects, have withdrawn from the labour force entirely and the economically inactive portion of the population has risen dramatically. The total number of workers in Kazakhstan fell by 15.6% between 1991 and 1996 (Griffin, 1998).

The fall in GDP has been accompanied by a growing incapacity of governments throughout the region to collect revenues. Real **allocations to the social sectors** have declined sharply. The total expenditure on health in CAR region in 1994/95 has been 37.7% lower than in 1990/91 (UNDP, 1998a). The most precipitous drop was noted in Tajikistan and Turkmenistan to a quarter and less than half of pre-independence levels, respectively. Despite the fact that public spending for health sector has significantly contracted, there have been little change in medical staffing and in-patient capacity in public health sector during the transition. Facing the growing costs of health services, a number of Central Asian countries declared their political will to reform health care systems to improve access to health services of good quality, based on primary health care. Nevertheless, the gap between principles and practice is large. Given the current preoccupation with curative care and the pressure of compelling problems of the declining health of the population, governments face the difficult trade-off in building the health promotion focus into policies and putting stronger emphasis on addressing HIV/AIDS issues.

The rise in economic measures of poverty (Fig.3) was accompanied with worsening of capability-based indicators of well-being including those reflecting **the health** of the population. The declining health in the Central Asian republics is clear across a number of morbidity and mortality indicators. In general, life expectancy fell between 1991 and 1995, and began to recover in 1996 and 1997. For example, male life expectancy at birth in Kazakhstan fell from 63.3 years in 1991 to 59.7 in 1995 (UNICEF, 1998a). Compare to other regions, the life expectancy at birth in Central Asian region has been in 1996 nearly five years less than in Central and Eastern Europe and eleven years less than in EU countries (WHO/Europe, 1997). Trends in infant mortality (Fig.4) show that Central Asian republics experienced sharp rises between 1991 and 1993 , and then improvements between 1993 and 1996. Still, infant mortality rates in Central Asia are significantly higher than average for CIS, Central and Eastern Europe and

Fig. 4. Infant mortality (per 1000 live births), over 1970-96

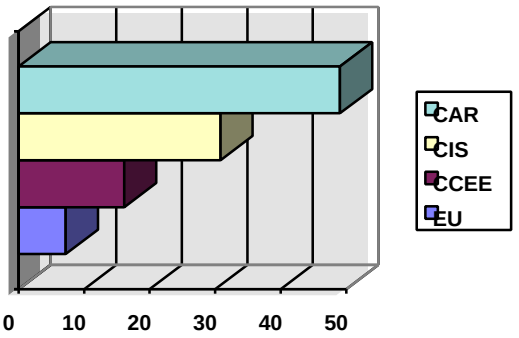


Source: WHO/Europe (1998)

EU. Tajikistan and Turmenistan had the highest infant mortality rates among the republics, with 47 (1993) and 46.4 (1994), respectively (WHO/Europe, 1998). Major causes of infant mortality in the Central Asian republics are acute respiratory diseases, perinatal conditions and acute diarrhoeal diseases, respectively (UNICEF, 1998b).

Under-five mortality, again, shows (Fig. 5) that Central Asian republics are worse off compare to the regions of CIS and Central and Eastern Europe.

Fig. 5. Under-five mortality (deaths per 1000 live births), 1996 or latest available

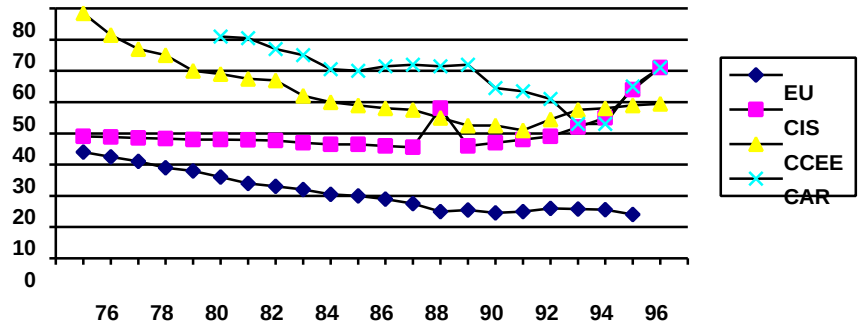


Source: WHO/Europe (1997)

Maternal mortality in Central Asian region is high by international standards and remains an issue of great concern. Among five Central Asian countries, Turkmenistan has the highest maternal mortality rate, though showing a steady decrease over the years, from over 130 in 1992 to 99.5 in 1995 (WHO/Europe, 1998). Official data from Uzbekistan shows that maternal mortality decreased two folds between 1993 and 1996, from 40.6 to 20.7. However, National Human Development Report refers that 43.5% of women have impaired health status which afflicts 60% of women in their childbearing years. More than 70% of pregnant women in Central Asian countries suffer from iron deficiency anaemia (UNICEF 1998b).

Another disease that is clearly related to poverty and economic disadvantage is tuberculosis. The strikingly high and growing incidence of tuberculosis in Kazakhstan and Kyrgyzstan (+28% and +55% over 1991-1996, respectively) (WHO/Europe, 1998) reflects the extent of the plight of the poor and largely contributes to the alarming pattern of the sub-regional trend (Fig. 6) which closely mimics the CIS average since 1993.

Fig. 6. Incidence of tuberculosis, per 100 000 population, over 1975-1996



Source: WHO/Europe (1998)

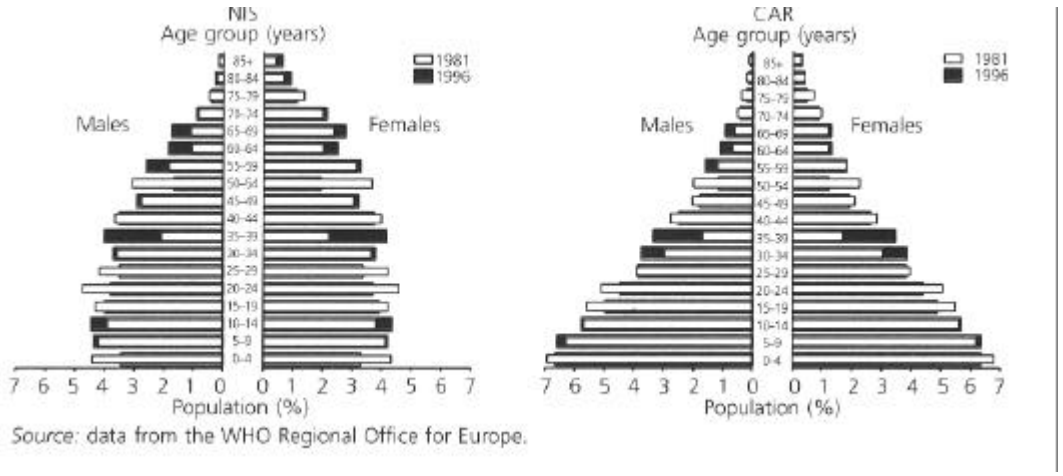
The drop in government expenditure on **education** services affected enrolment rates in Central Asia. The most negative trend was observed in pre-primary school enrolment which fell, between 1991 and 1995, more than two folds in Kazakhstan and three folds in

Kyrgyzstan (UNICEF, 1998a). General secondary enrolment also dropped over 1991-96 by 23% in Kazakhstan, 26% in Uzbekistan and 41% in Tajikistan which is particularly alarming as it compounds the problem of street kids. Adolescents leaving school and facing growing obstacles in employment or continuing education are increasingly turning to criminal activity and experimentation with drugs and unprotected sex.

The economic and capability-based indicators of well-being in Central Asia, some of which were illustrated above, clearly show that the transition negatively affected a material standard of living of the significant part of population and severely restrained an individual's capacity to live a healthy life, free of avoidable morbidity, have adequately nourishment and be informed and knowledgeable. This draws a picture of the people in Central Asia being vulnerable to HIV/AIDS due to the constraints on the way of individual empowerment through the access to health and social services, information and health education and a supportive social environment.

An important demographic feature of the sub-region is **young age structure** (Fig. 7) that

Fig. 7. Changes in population structure over 1981-1996



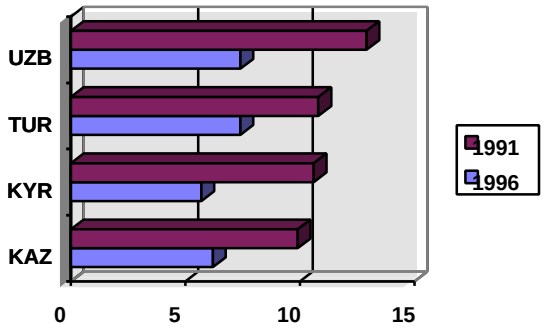
Source: data from the WHO Regional Office for Europe.

the Central Asian countries continue to have over the transition. The five Central Asian countries contain over 23 million children - one-fifth of all the children in the 27 countries of Central and Eastern Europe and CIS (UNICEF, 1998a). Within Central Asia, population under 18 represent about 43% of the total population ranging from 35% in Kazakhstan to 47% in Tajikistan (UNICEF, 1998c). Young people constitute the group at high risk of slipping into poverty and erosion of their living standards and future prospects. This gives more strength to the argument that young people should be placed into a focus of HIV/AIDS, STD and drug abuse prevention activities in the sub-region due to their vulnerability for both socio-economic and behavioural reasons.

The populations in Central Asia are expanding quite rapidly in spite of the decrease in births caused partly by the reduction in the number of marriages (Fig. 8). Given that marriage in

Central Asia was, until recently, virtually universal, falling marriage and birth rates may reflect a lack of confidence in the future that affects individual's decision to marry, divorce and have children. The rise in divorce between 1991 and 1995 has been modest in Tajikistan and Uzbekistan but more pronounced in Kazakhstan (13.5%), Kyrgyzstan (17.4%) and Turkmenistan (25%) (UNICEF, 1998a). Increased stress on **familial relations** (that have been seen traditionally strong in Central Asia) may be related to the struggle to get by on lower incomes, rising unemployment and the general economic uncertainty. Falling marriage and higher marital breakdown, thus, are another factors that stem from the transition and social distress in Central Asia and should be seen in HIV/AIDS context as they influence individual behaviour and vulnerability.

Fig. 8. Crude marriage rate change, no. marriages per 1,000 population



Source: UNICEF (1998a)

Important demographic change in Central Asia has also been the large **population movements**. According to estimates by the UN High Commissioner for Refugees, over four million people have moved within or from Central Asia since the late 1980s. Among these, 700,000 were displaced during the civil war in Tajikistan (most of whom have returned since); 250,000 have left ecological disaster areas (the Aral Sea and the nuclear test area of Semipalatinsk), and around two million have returned to their ethnic 'homelands' outside Central Asian region, in addition to large movements within countries (for example, from south to north Kyrgyzstan) (UNICEF, 1998a).

The search for job is largely the reason of mass influxes of rural populations to urban areas which is of particular importance for the sub-region as the population of Central Asia is predominantly rural, from about one-half in Turkmenistan to three-quarters in Tajikistan, with the exception of Kazakhstan, where the urban population is larger. Having faced the lack of employment opportunities in the cities people are likely to join the underground economy, engage in commercial sex or criminal activities including drug trafficking. The countries of Central Asia have seen also a significant increase in international travel by their nationals including 'shuttle retailers' (or 'shop-tourists') that regularly visit foreign countries to buy goods and sell them back home. Another important occupational grouping at risk of STD and HIV/AIDS acquisition is long-distance truck drivers and their helpers, given the advanced transport communications and transparent interstate borders within the region. These mobile populations are at higher risk of STD and HIV due to the fact of being away from home and community, and therefore facing the anonymity and loneliness of travelling. Trans-border movements between Tajikistan and Afganistan, the major heroin-producing area, is of particular concern from the drug trafficking stand point.

In summary, the economic dislocation in Central Asian countries at the rupture of the USSR has been substantial due the loss of transfers and post-Soviet trade disruption and was followed by the rapid social change. This has led to a number of consequences associated with increased risk of HIV spread including economic hardship and rise in poverty, increased pressures on social sectors, high mobility of population, decline in the health of the people, changes in life styles and familial relations. Young age structure of populations is another feature of the sub-region that has clear implications in the HIV/AIDS context.

1.2 RISK AND VULNERABILITY: SITUATION WITH HIV/AIDS, STD AND SUBSTANCE USE

1.2.1 HIV/AIDS

Following detection of the first cases of HIV infection in the sub-region in the late 1980s - early 1990s that could be traced mainly to sexual contacts with infected persons residing outside the region, HIV incidence in Central Asia was remaining very low. The data from massive routine screening of vast populations including, apart from blood donors and recipients, various groups of behavioural and occupational risks, clinically suspected patients, as well as travellers, foreigners and other categories show that the Central Asian region has been very slightly touched by HIV (Table 1).

Table 1. **Sub-regional HIV/AIDS statistics, 31 December 1998**

Country	Year HIV first reported	Reported cumulative HIV+ cases	Reported cumulative AIDS cases	Predominant mode of transmission
Kazakhstan	1989	815 (including 27 foreigners)	24 (17 died)	IDU (82.5%)
Kyrgyzstan	1987	26 (including 20 foreigners)	-	heterosexual
Tajikistan	1991	3	-	heterosexual
Turkmenistan	1997	1	-	heterosexual
Uzbekistan	1992	48 (including 27 foreigners)	7 (died)	heterosexual (87%)

Source: National AIDS Centers

By the middle of 1996, however, it had become evident that HIV infection is introduced and increases with great velocity in the northern part of Kazakhstan, in Karaganda oblast and particularly Temirtau town. 163-fold growth in HIV incidence in Kazakhstan over 1995-1998 (Fig. 9) is mostly attributable to this localised outbreak among injecting drug users in Karaganda/Temirtau (Box 1).

1.

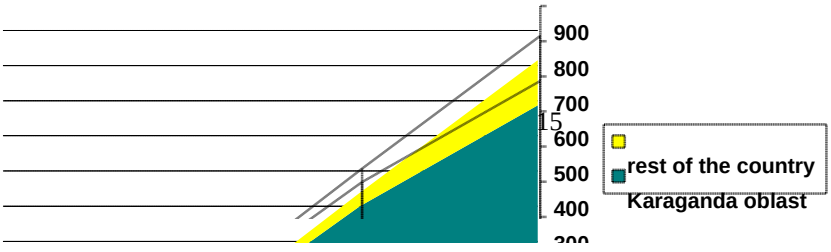
CASE BOX. *TEMIRTAU STORY*

Karaganda and Jezkazgan oblasts (coloured in black) are the two highly industrialised provinces that form the Central Kazakhstan region. The main industries are coal mining and metallurgy, and the flagship enterprise is the steel plant in Temirtau town of Karaganda oblast.

REGIONS OF KAZAKSTAN

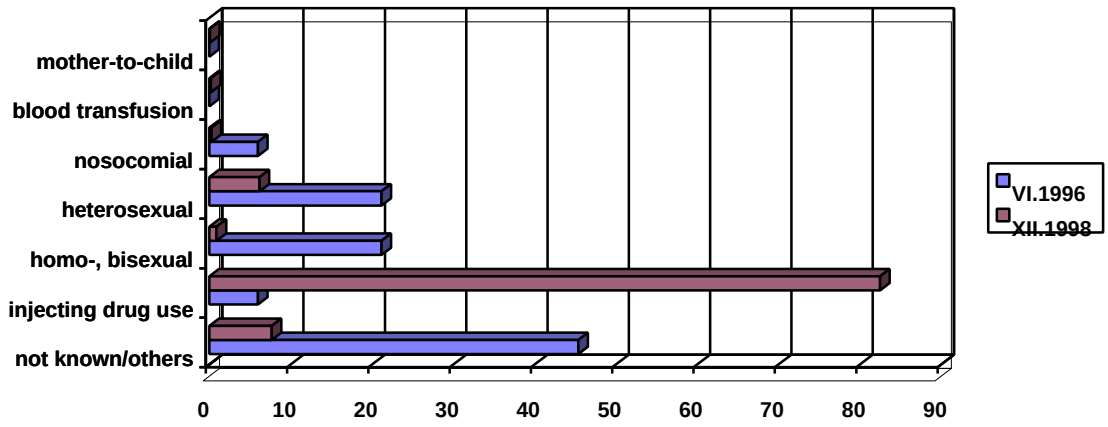
Regions of Kazakstan	Territory, %	Population 12.01.89, %
WEST KAZAKSTAN	26.6	12.8
NORTH KAZAKSTAN	22.0	26.8
SOUTH KAZAKSTAN	26.4	38.5
CENTRAL KAZAKSTAN	15.0	11.2
EAST KAZAKSTAN	10.0	10.7

Fig. 9. Reported HIV incidence in Karaganda oblast and the rest of the country over 1995-1998, no. of cases



The change in the pattern of HIV infection spread is clearly seen in a shift from the predominantly sexual modes of transmission, among the known ones, before mid-1996 to the injecting drug use since then (Fig. 10). At present IDU account for over 80% of HIV-infected in Kazakhstan.

Fig.10. HIV infection by mode of transmission in Kazakhstan before and after the start of outbreak in Temirtau, %

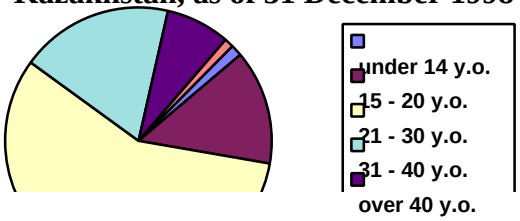


Source: National AIDS Center

The high proportion of young people among those infected is of particular concern (Fig. 11). The age group of 15 - 30 y.o. account for 71,2% of reported HIV-positive cases.

In summary, HIV infection is already introduced in Central Asian region and rapidly growing in Kazakhstan that

Fig. 11. HIV infection by age group in Kazakhstan, as of 31 December 1998

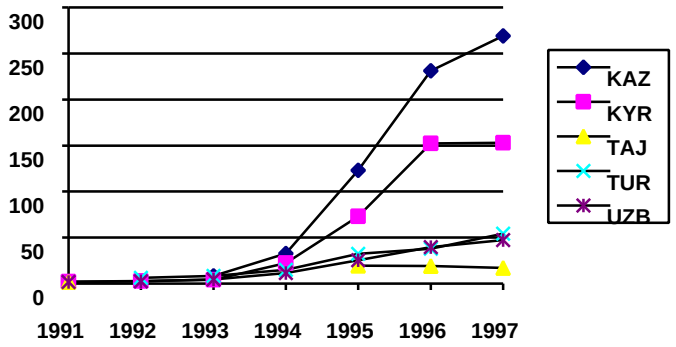


faces a concentrated epidemic among IDU in Northern region, though all the other oblasts have become affected by now. Given the existence, across the Central Asian region, of factors that may facilitate the spread of HIV, particularly STD epidemics and rise in drug trafficking and abuse, the threat of fast growth of HIV/AIDS in the region becomes very serious and it might be a matter of few years or less before the infection will gain a foothold.

1.2.2 STD

A key signal of the potential for HIV infection growth in Central Asia is the dramatic increase in STD (Fig. 12). Over the years of transition the reported syphilis rates have risen in all the Central Asian countries, with the most drastic growth in Kazakhstan (135 folds) and Kyrgyzstan (77 folds).

Fig. 12. Incidence of syphilis, per 100,000 population, over 1991 - 1997



Source: WHO/Europe (1998), National STD centers

Alongside the socio-economic changes, erosion of family values and the increase in mobility of population, described above in Section 1.1, Central Asian countries have experienced a significant increase in both casual and commercial sex amongst their populations. There are differences in patterns of STD spread in different Central Asian countries that show country-specific trends (Box 2), as well as similarities, especially when it comes to the factors that determine vulnerability of population groups at risk (Box 3).

The STD situation in Central Asia is compounded due to the late presentation of syphilis patients to medical services. In Uzbekistan percentages of syphilis cases in primary stage and in early secondary stage are low and continue to decline: from 17% in 1995 to 16% in 1996 and 15,3% in 1997 for primary syphilis and from 25% in 1995 to 23 % in 1996 and 21,7% in 1997 for early secondary syphilis. In Kyrgyzstan patients with primary and early secondary syphilis accounted for 25,6% of STD patients in 1995, 19,5% in 1996 and 15,5% in 1997. In Kazakhstan also, increasingly it is latent syphilis that is being diagnosed through the syphilis screening programmes so that the proportion of reported cases of

primary and secondary syphilis has decreased from 51% in 1994 to 35% in 1996. The confinement of the majority of those diagnosed with STD for treatment and lack of confidentiality discourage people from accessing STD service at an early stage.

2. **CASE BOX.** ***WARNING TRENDS IN STD SPREAD***

Kyrgyzstan and **Kazakhstan** STD services report about the appearance of congenital syphilis and marked increase in syphilis incidence among children and adolescents. While before 1995 there was virtually no indication of congenital syphilis in Kyrgyzstan, since then the number of cases has grown from 12 in 1995 to 45 in 1997 and 56 within eleven months of 1998. Likewise, in Kazakhstan the notable incidence of congenital syphilis, 1.1 per 1,000 childbirths, has been first reported in 1995. The syphilis incidence among adolescent girls aged 15-17 in Temirtau town, Kazakhstan (the site of HIV outbreak), was found to be 700 per 100,000 which is 2.6 times higher than the country average, clearly indicating that young people are exposed to unprotected intercourse. Syphilis rate among adolescents 14-17 y.o. in Kyrgyzstan has grown two-fold between 1995 and 1997.

Uzbekistan STD service refers to a warning trend of STD growth among rural population which has risen to account for 31% of registered syphilis cases in 1998. STD service believes that this pattern may reflect the burden of poverty and unemployment that push people for migration in search for job. An alarming trend is also rapidly increasing STD rates among women which, since recently, started to exceed the rates among men and are viewed indicative of growing number of non-marital sexual encounters. Higher syphilis rates among women, compare to men, have also been first ever time reported in **Turkmenistan** in 1996.

Tajikistan STD service reports on the emergence of the risk groups which were previously unknown such as military forces and police that are extensive in the country suffering civil unrest.

The rise in new cases of STD reflects both a dramatic increase in unprotected sex and impaired efficiency of the service combined with the low trust in service among clients. The reasons for the low confidence in state STD services include discriminatory system of STD case management with registration of patients and confinement for in-patient treatment; compulsory contact tracing; provision of care by STD specialists only; delays, sometimes substantial, of treatment until results of laboratory tests are known (Kyrgyzstan, Tajikistan); lack of diagnostic kits for some diseases especially in the periphery of the country (e.g. for urogenital chlamydial infection in Kazakhstan).

The lack of trust in STD service among clients is indirectly confirmed, as widely believed by STD specialists across the region, by low and further declining rates of gonorrhoea, in contrast with rocketing levels of syphilis, for the reason that the vast majority of gonorrhoea patients are self-treated or treated by unlicensed ‘underground’ practitioners. For instance, in Kazakhstan the gonorrhoea incidence remained close to 1990 level over the last seven years while syphilis incidence has risen 135 fold. Gonorrhoea to syphilis ratio has decreased in Tajikistan from 11.7 in 1991 to 0.4 in 1997. Similarly, this ratio declined in Turkmenistan

3. **CASE BOX.** ***VULNERABILITY OF SEX WORKERS AND MEN HAVING SEX WITH MEN: FACTORS AT PLAY***

UNAIDS-assisted rapid assessments of the **commercial sex scene** have been conducted in Bishkek (Kyrgyzstan), Almaty (Kazakhstan), Ashgabat (Turkmenistan) and Tashkent (Uzbekistan) in 1997 and produced findings that are largely common across the countries including

- numbers of sex workers and their clientele grow rapidly
- sex industry is being organised with the emergence of different categories of sex workers ranging from highly paid call girls and escort agency workers to cheap street prostitutes, as well as operators linking within and between some circuits
- health care seeking behaviour and ability to negotiate safer sex vary greatly between the circuits with

In summary, strikingly high STD rates in Central Asian countries considerably aggravate the threat of HIV growth for reasons of behavioural risk overlap and synergy in transmission. Having stemmed from a mixture of socio-economic and behaviour changes over the transition period and exacerbated by the deficiencies in health services, the problem of STD growth has reached the magnitude of a top priority that requires immediate and effective response. High vulnerability of populations at particular risk (sex workers and MSM) calls for targeted interventions among them.

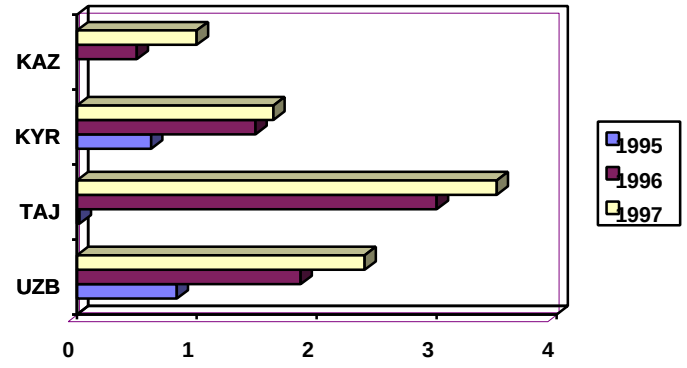
1.2.3 DRUGS SPREAD AND ABUSE

The geographical location of the region and the ongoing difficult political and economic transition make the Central Asian countries vulnerable to drug trafficking and abuse. Central Asian subregion has turned into a major route for illicit transit of drugs from Afganistan,

that accounted for 58% of world illicit opium production in 1997, to Western Europe and the USA. Weak control on borders, limited capacity of the Central Asian Republics for effective interdiction efforts and deficiencies in law enforcement systems contribute to the perception of a relatively low risk associated with illicit transit in the region. Advanced transport communications and transparent interstate borders within Central Asia facilitate drug trafficking.

The 1997-98 Annual report of UNDCP Regional Office for Central Asia refers to significant rise in drug trafficking in recent years (Fig. 13). Tajikistan is seen to be a key conduit for illicit drug trafficking in the region due to the political and economic instability in the country. The country has been profoundly affected by the consequences of a civil war, the collapse of the national economy and the dramatic increase of the number of poor people in the population, who are increasingly involved in illicit activities and, in part, responsible for the drastic increase in the flow of opium and heroin from Afganistan across the 1,700-km-long border.

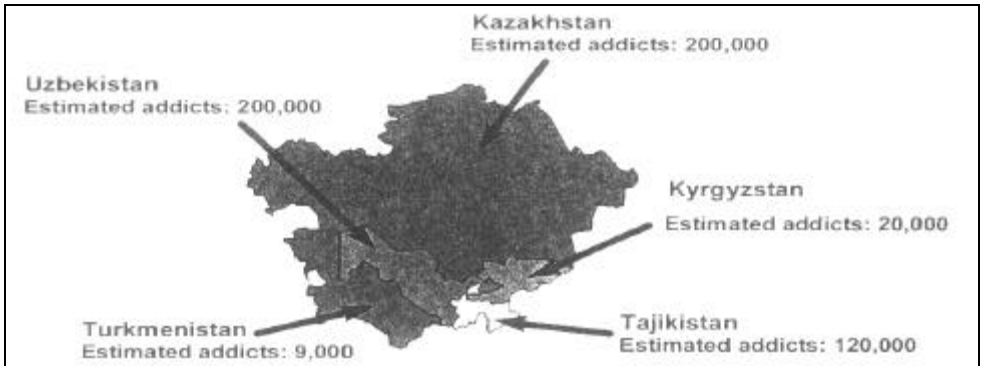
Fig. 13 Opium seized over 1995-1997, tonnes



Source: UNDCP (1998)

Some of Central Asian countries are sizeable producers of illicit cannabis, opium and ephedrine with high potential for becoming even greater source of these drugs. It is estimated that the total area under illicit opium poppy cultivation in Kazakhstan is around 2,000 hectares, and total opium production amounts to approximately 30 metric tonnes (UNDCP, 1998). Kyrgyzstan was once one of the world's largest supplier of licit opium poppy. After the Soviet ban on opium poppy cultivation in 1973, illicit cultivation continued. Illicit drug cultivation is also on the rise in Tajikistan and Turkmenistan, occurring mainly in remote mountain and desert areas and on small local plots.

With increased trafficking of illicit drugs within and through Central Asian states, the last decade has seen a significant rise in both the number of persons abusing drugs and in the incidence of drug addiction. The main drugs of abuse are opium derivatives (liquid tinctures for the preparation of teas or intravenous injections, extracted in simple processing stages from poppy straw), cannabis products and psychotropic substances.



According to the Committee of Health of Kazakhstan, over 26 thousand drug users were registered in country at the end of 1997. It is believed by domestic and international experts that the number of drug users is several times this figure, with some Government estimates going as high as 200,000. There has been rapid growth in drug use in Kyrgyzstan during recent years, with the rate of drug use in 1995 (47,4 per 100,000 population) 12,5 times higher than in 1991. At the moment there are 5,000 registered drug users in Kyrgyzstan, with the estimated figures being five to ten times higher. The number of registered drug users in Uzbekistan is slightly over 15,000. Health officials report approximately 44,000 users, but estimate there could be as many as 200,000.

The social profile of registered drug addicts reflects high percentage of individuals who are unemployed and not studying. This category accounts for 55% of registered drug abusers in Kazakhstan (1996) and 56,5% in Tajikistan (1997). Urban workers, at over 21% of the total number of registered drug addicts in Kazakhstan, are the next largest category, followed by rural workers at about 9% and students and school children at 6,6%. In contrast with Kazakhstan, the rural residents in Tajikistan appear to be affected almost as much as urban workers (16% and 17%, respectively). High percentage of rural residents among identified drug addicts in Tajikistan may be viewed indicative of spillover effects of drug trafficking in country-side particularly in mountainous Gorno-Badakhshan region that neighbours Afganistan and is known by intensive cross-border movements. Government officials in Tajikistan believe also that drug addiction among teenagers is on drastic rise.

The most serious drug abuse trend in the sub-region in recent years has been the rise in the use of injected drugs, primarily opiates, and the associated outbreak of HIV among IDU in Karaganda oblast of Kazakhstan, as described earlier in Section 1.2.1. UNAIDS-assisted rapid assessments of injecting drug use and HIV situation in five cities of Central Asian sub-region were instrumental in gathering behavioural information and underscored an enormous potential for rapid growth of HIV infection among IDU and from this core group further (Box 4).

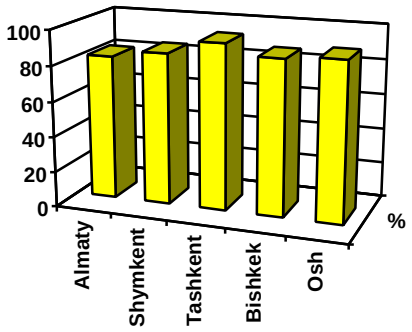
4.

CASE BOX. ***RAPID ASSESSMENT AND RESPONSE TO IDU AND HIV SPREAD IN CENTRAL ASIA: HOW BIG IS THE PROBLEM?***

UNAIDS-assisted RARs have been conducted in Almaty and Shymkent (Kazakhstan), Tashkent (Uzbekistan) and Bishkek and Osh (Kyrgyzstan) in 1998 with the view to study the prevalence of injecting drug use and collect behavioural information about drug users in HIV-relevant context.

RARs produced estimations of numbers of IDU in assessment sites that surpass official data 10-15 fold. The most commonly used drug is raw opium which is easily transformed by simple preparation into ready-for-use drug called ‘hanka’; hanka accounts for 75% of all the drugs in use in Almaty and 97% in Bishkek.

The age structure of IDU shows that one third of IDU are young people under 25. The majority



2. UNAIDS-ASSISTED RESPONSE IN CENTRAL ASIAN COUNTRIES

2.1 ROLE OF UN THEME GROUPS AND ICPA. OVERVIEW OF MAIN DIRECTIONS OF ASSISTANCE AT COUNTRY AND INTER-COUNTRY LEVEL

UN assistance in the field of HIV/AIDS and STD prevention has been provided to Central Asian countries starting 1994, initially under WHO Global Programme on AIDS (1994-95). Since 1996, UN support in this field is being led by UNAIDS and its co-sponsors through UN Theme Groups on HIV/AIDS backed up by ICPA, stationed in Kazakhstan.

UN Theme Groups on HIV/AIDS were established in the countries of the sub-region in 1996 under the UN Resident Coordinator system. UNDP Resident Representatives act as UN Theme Group Chairs with the exception of Uzbekistan where, since 1998, the Group is chaired by the Director of the Regional UNDCP Office for Central Asia.

UN Theme Groups in Central Asia relatively quickly moved from initial set-up and information exchange stage to establishing a close dialogue with Governments and then to more coordinated action focusing on advocacy, programme frameworks development and resource mobilisation. A notable example of the progress achieved by the UN Theme Group in bringing coordination effort into an advanced form of integrated planning and joint implementation of multi-donor activities is the experience of Theme Group in Kazakhstan (Box 5) which illustrates also the successful approach towards co-opting other donors and expanding resource base for HIV/AIDS-related programmes.

Some common characteristics of UN Theme Groups operation in the sub-region include:

- the involvement of UNAIDS co-sponsors is uneven, with the most strong role played by UNDP
- UNESCO has been very active in providing technical expertise both to national and inter-country projects under coordination from Regional Communication Office
- UNFPA shows growing commitment to address HIV/AIDS-related problems by integrating them as important targets into UNFPA-assisted projects, as particularly applies to Kyrgyzstan where UNFPA supports two projects on sex education that put strong emphasis on HIV/AIDS prevention
- Theme Groups are expanded, with representation from Government, NGO and international partners (e.g. international NGOs); in some countries (Turkmenistan, Kyrgyzstan, Tajikistan) joint meetings of Theme Groups and National AIDS Coordination Committees are exercised to foster the top policy dialogue
- UNDCP plays increasingly important role that advances from co-funding the HIV/AIDS-related programme (Kazakhstan) to taking the lead in programme initiation and execution support (Uzbekistan)
- consistent effort is made by the Theme Groups to participate in the health donor group dialogue in-country and, thus, to open up possibilities for sensitising and co-opting bi- and multi-lateral donors.

5. **ACHIEVEMENT BOX.** ***UN THEME GROUP IN KAZAKHSTAN ACTS AS A DRIVING FORCE IN MOBILISING RESPONSE TO HIV OUTBREAK ON SPOT WHILE ENSURING SUSTAINED BACK UP AT NATIONAL POLICY LEVEL***

With the view to assist the country to promptly respond to HIV outbreak in Northern Kazakhstan and to expand this response nation-wide within the broader health and social context, UN Theme Group in Kazakhstan has mobilised a consolidated UN inter-agency effort and established a productive dialogue with the national partners through two-fold process.

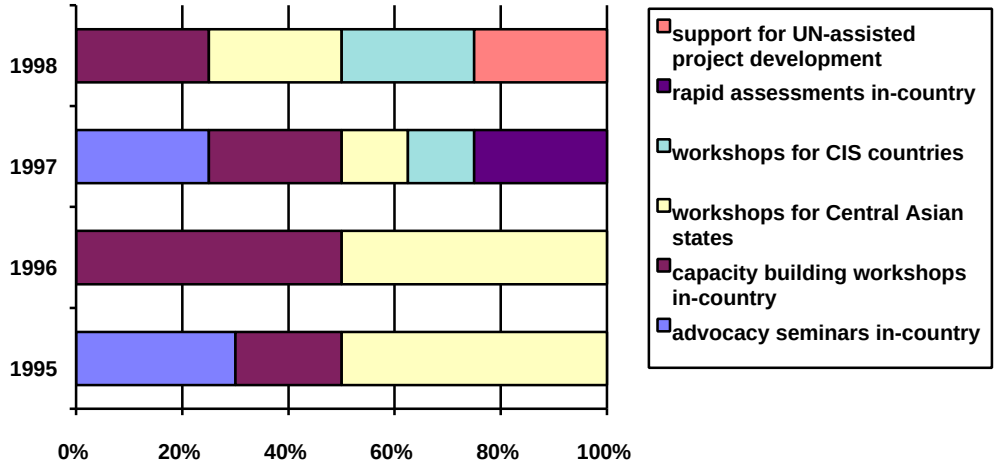
The first process has been the assistance provided by the pilot project in Temirtau following the exploratory inter-agency mission to HIV outbreak site in March 1997. The mission comprised

UNAIDS-assisted response in Central Asian countries has been gradually progressing over the two-phase period. In 1996/97 the assistance was aimed at sensitisation of national counterparts to effective approaches in HIV/STD prevention through advocacy, along with building institutional cooperation and coordination mechanisms; this was followed by strengthening technical capacity of national specialists and NGOs in parallel with programming for action. For 1998/99 the main priorities of UNAIDS-assisted activities in the sub-region include further programming for action, operationalisation of projects, resource mobilisation and expanded partnership building. At present, the main focus of collaboration with national partners is to build further on the grounds created through advocacy, institution and capacity building and setting up programmatic frameworks with the view to secure strong political support for effective practical action.

Prior to the emergence of development projects supported by UNAIDS and its co-sponsors, Central Asian countries were targeted by UNAIDS-facilitated assistance that included wide range of advocacy and capacity building workshops and seminars in-country and for the sub-region, as well as Rapid Assessment and Response studies and continuous advice and facilitation support from ICPA. The breakdown of major types of UNAIDS assistance that

covered Uzbekistan during 1995-1998 (Fig. 15) is illustrative for other countries of the sub-region and shows that during 1995-1996 the significant effort was made to sensitise Central Asian countries to newer approaches through sub-regional meetings, in-country advocacy and technical capacity building workshops. In 1997-1998 a wider range of assistance services was delivered to the country including, apart from continuing advocacy and capacity building exercises, rapid assessments of vulnerability among risk groups, exposure to exchange of experiences within CIS region and support for the development of UN-assisted national project.

Fig. 15. UNAIDS-assisted activities that covered Uzbekistan in 1995-1998



Source: UN Country Office in Uzbekistan

By 1997-1998 the UNAIDS-facilitated dialogue in all the Central Asian countries has advanced to the stage of development and operationalisation of collaborative UN-assisted projects pursuing HIV/AIDS, STD and drug use prevention targets (Table 2). As can be seen from the Table, the resource and support base for the projects reflects expanding partnerships where UNAIDS, UNDP, UNFPA are the major sources of financial and technical assistance, UNDP provides administrative support, UNESCO has a strong presence in most of the projects for technical back-up on IEC part, and UNDCP plays increasingly important role on drug demand/harm reduction side. Important breakthroughs with regard to partnership building and resource mobilisation have been securing cost-sharing from the Government for UN-assisted project in Kyrgyzstan and involvement of private business in Kazakhstan for sharing the cost of intervention project among IDU in HIV outbreak site.

Table 2 **UN-assisted projects aimed at HIV/AIDS, STD and drug use prevention in CAR**

KAZAKHSTAN
(1) Project title and duration: ***Promotion of multi-sectoral effective response to***

HIV/AIDS and STD epidemic and drug use spread in Karaganda oblast and nation-wide; Two years
Status: Operational since May 1997
Key strategies: IEC strategy development and implementation; building the managerial and technical capacity of authorities and health services; community involvement and targeting vulnerable groups with focused interventions; strengthening multi-sectoral coordination, monitoring and evaluation; building the policy-making and organisational capacity of the National AIDS Center
Budget: USD 380,260
Resource and support base*: UNAIDS (F,T), UNDP (F,T,A), UNDCP (F), Private Company ISPAT-KARMET (F,IK), UNESCO (T), UNFPA (IK), Government (IK)

(2) Project title and duration: ***Multi-donor integrated assistance programme on healthy lifestyle development; Two years***
Status: Programme document formulated; currently under final consideration with stake holders
Key strategies: Improvement of policies and legislation in the areas of HIV/AIDS, STD, drug demand/harm reduction, family planning and reproductive health; building cross-sectoral cooperation and organisational capacity; social mobilisation; targeting vulnerable groups with pilot initiatives and their reflection in national policy dialogue; integration of sub-sectoral programmes with healthcare reform.
Budget: USD 807,700
Resource and support base: UNAIDS (F,T), UNFPA (F,T,A,IK), UNDP (T,A), UNESCO (T), UK Know How Fund (F), Government (IK)

KYRGYZSTAN

(1) Project title and duration: ***Safer sex education promotion in Bishkek city; One year***
Status: Started end 1995, completed end 1996
Key strategies: Safer sex education among youth, condom promotion and distribution, development and production of information materials on HIV/STD prevention and reproductive health promotion
Budget: USD 85,000
Resource and support base: UNFPA (F,T), UNDP (A), UNAIDS (T), Government (IK)

(2) Project title and duration: ***Prevention of STD and HIV/AIDS in Kyrgyz Republic; Two years***
Status: Operational since April 1997
Key strategies: Building capacity for multi-sectoral response; IEC, peer education and counselling strategies for behaviour change; capacity building for safe blood and medical practices.
Budget: USD 600,000
Resource and support base: Government (F,IK), UNDP (F,A), UNAIDS (F,T), UNESCO (T)
(3) Project title and duration: ***IEC and training on reproductive health, STD and HIV/AIDS in Kyrgyzstan; Three years***
Status: Operational since May 1998
Key strategies: Improvement of awareness about responsible and safe sexual and reproductive health behaviour; building the capacity for interpersonal communication and counselling; improvement of quality and access to relevant health services
Budget: USD 253,000
Resource and support base: UNFPA (F,T), UNDP (A), UNAIDS (T), Government (IK)

TAJIKISTAN

Project title and duration: ***Promotion of a multi-sectoral response to HIV/AIDS and STD in Tajikistan; Two years***
Status: Project document developed, resource mobilisation underway
Key strategies: Strengthening the capacity for improvement of policy and legislation and programme management/coordination; enhancement of technical skills of relevant health services; IEC strategic plan development and implementation; targeting vulnerable groups with focused interventions; support for blood safety assurance; piloting on key preventive strategies in a selected region.
Budget: USD 227,100
Resource and support base: UNAIDS (F,T), UNDP (A), UNESCO (T), others to be determined

TURKMENISTAN

Project title and duration: ***Strengthening HIV/AIDS prevention strategy in Turkmenistan; 15 months***
Status: Operational since December 1998
Key strategies: Strengthening multi-sectoral collaboration; improvement of relevant legislation; information support to AIDS centers and their networking; technical capacity building of health and education specialists and NGOs; strengthening IEC activities.
Budget: USD 80,000
Resource and support base: UNDP (F,A), UNAIDS (F,T), UNFPA (F,T), WHO (F,T), UNESCO (T), Government (IK)

UZBEKISTAN

Project title and duration: ***Promotion of effective response to HIV/AIDS, STD and drug abuse in Uzbekistan; Two years***
Status: Project document developed, resource mobilisation underway
Key strategies: Enhancement of capacity for policy and legislation improvement and for programme management and coordination; building the technical capacity of relevant services; social mobilisation through IEC; assistance to vulnerable groups through pilot interventions; support for effective evaluation and monitoring of programmes.
Budget: USD 478,200
Resource and support base: UNDCP (F,T,A), UNAIDS (F,T), UNESCO (T), others to be determined

***Note:** Abbreviations for types of assistance: A - administrative support; F - funding; IK - in-kind contribution; T - technical assistance

Another notable examples of partnership building include co-opting international partners, often with rather limited resources, from within and outside UN for specific interventions by articulating a good match between project goals and donor priorities and creating enabling environment for the impact of their assistance to sustain within broader programmatic frameworks (Box 6).

6. **ACHIEVEMENT BOX.** ***GOOD LEVERAGE FOR SCARCE RESOURCES MOTIVATES DONORS TO COME ON BOARD***

With limited financial resources, **WHO** has made a significant impact on STD prevention side where the specific technical expertise mobilised by the organisation was built into the ongoing process of multi-partite collaboration and reinforced by complementary efforts of other partners. WHO considerably contributed to initiation of interventions among vulnerable groups having supported, both financially and technically, the conduct of RARs on MSM vulnerability in

Support for inter-country activities, networking and exchange is seen an important priority of the sub-regional strategy on HIV/AIDS, STD and drug use prevention. Various types of assistance are being provided from the sub-regional perspective that fall into the following major components (Table 3).

Table 3 **Facilitation of inter-country dialogue and networking in Central Asia**

Component	Brief description
⇒ Inter-country project	Sub-regional IEC Project along the Silk Road was developed and put into operation in 1996, following the initiative raised by UNAIDS and UN Theme Groups. With the Regional UNESCO office taking the lead, the project

	supports, on a sub-regional basis, publication of a newsletter INTO FOCUS, cross-border campaigns on safe sex and condom promotion, training programme in communication and public relation techniques, and HIV/AIDS awareness workshops for senior mass media practitioners, editors and journalists.
⇒ Inter-country technical advisory group	The Silk Road project implementation is facilitated by Inter-Country Coordinating Team on Technical Advisory Services (IEC) which meets on a quarterly basis in the countries of the region.
⇒ Consultancies by specialists from CAR sub-region and CIS region	A number of consultancies have been undertaken by CAR and CIS experts to facilitate networking and share experiences in key areas encompassing rapid assessments of risk and vulnerability (IDU, MSM), counselling techniques, sentinel serosurveillance, clinical care, as well as programme and project development. Consultants involved with inter-country technical cooperation represent Russia, Ukraine, Belarus, Kazakhstan, Kyrgyzstan and Uzbekistan.
⇒ Inter-project visits and study tours within CAR and CIS	Through inter-project visits the project staff from Kazakhstan and Kyrgyzstan was familiarised with the experience of similar projects in Ukraine, and the project team from Turkmenistan was sensitised to the progress achieved by Kyrgyz project. Issue-specific exposure to policy and practices of Ukraine in addressing HIV problem in prisons was provided to Kyrgyz and Kazakh specialists through study tours.
⇒ Sub-regional trainings	A range of sub-regional workshops was organised in Central Asian countries on UNAIDS strategic priority areas to synchronise the capacity building process across the region and provide forum for exchange of views and experience.

Assistance that UNAIDS and co-sponsors provide to Central Asian states through country-specific and inter-country activities does make a change in how the countries respond to pressing problems of HIV/AIDS, STD and drug use spread.

2.2 COORDINATION OF MULTI-SECTORAL COOPERATION

In countries of Central Asia, the recognition of the need in an expanded multi-sectoral response to growing threat of HIV/AIDS and the actions towards the establishment of national coordination bodies were advancing with different speed. The way this process related to the development of HIV/STD policy frameworks was also different from country

to country: in **Kazakhstan** a cross-sectoral coordination committee was set up in September 1995 with the view to shape the process of national programme development; in **Tajikistan** the formal adoption of the national HIV/STD policy was synchronised with the establishment, in April 1997, of a national committee (Box 7) for turning the policy into action; in **Kyrgyzstan** the national policy which was developed in 1996 envisaged the establishment of a cross-sectoral national committee as a key start-up activity (accomplished in September 1997); and in **Turkmenistan** and **Uzbekistan** coordination committees are still under formation, though national policies are developed and call for strong cross-sectoral cooperation.

Although Kazakhstani national multi-sectoral committee has been the first one set up in Central Asia and was centrally placed for mobilising broad-based response across the sectors (being established at Vice Prime Minister office), it has not been fully functional during the last two years mainly due to frequent reshufflings in the Government. In November 1998 the Committee has been reassembled under the chairmanship of the Minister of Education, Culture and Health. This structure implies the possibility for coordination between the three constituent committees but limits the authority to actively co-opt other key sectors such as mass communication, law enforcement, justice, finance etc.

Coordination mechanisms in Kyrgyzstan, although established relatively recently as a follow-up step to the approval of National HIV/AIDS/STD Programme, may nevertheless be considered exemplary in terms of technical backstopping of the National Coordination Committee by thematic advisory groups and effective decentralisation of cross-sectoral cooperation (Box 8).

ACHIEVEMENT BOX. *MULTI-SECTORAL COORDINATION IN KYRGYZSTAN: SUBSTANTIVE GUIDANCE AND SUPPORT FOR DECENTRALISATION*

8.

National Multi-Sectoral Committee has been set up in Kyrgyzstan in 1997 with the representation of all the key relevant ministries and agencies of the Government and is chaired by Vice Prime Minister. Technical advisory groups were established to provide substantive back-up to the Committee in the areas of policy and legislation improvement; epidemiological monitoring; information, education and counselling, and ethical aspects of HIV/STD-related problems.

The immediate steps that the National Committee has taken after its establishment were i) discussion and agreement on the multi-sectoral and multi-level work plan to underpin the

2.3 POLICY FRAMEWORKS IN THE AREAS OF HIV/AIDS, STD AND DRUG DEMAND/HARM REDUCTION

Following the National HIV/AIDS Policy Consensus Conferences that took place in 1995 in countries of the sub-region, Central Asian states embarked on the strategic planning process in HIV/AIDS and STD areas. The strategy development exercise was aimed at substantial revision of the pre-independence HIV policies that were fully based on the principles of the former USSR policy and included, as main priorities, epidemiological surveillance through massive mandatory testing, case finding and contact tracing as well as control over risk behaviour groups. This approach was almost totally lacking preventive focus, did not promote multi-sectoral and multi-level partnerships and was unfit for putting forward focused interventions to target vulnerable groups and geographic areas where HIV is an emergency.

The process of strategic planning was supported by a series of UNAIDS-assisted workshops on programme development and has taken in average two years for most of the Central Asian countries to formulate the progressive HIV/STD programme for the period of three to five years.

In two countries, Tajikistan and Kyrgyzstan, the National Programmes on HIV/AIDS and STD Prevention are already formally adopted (Table 4). In two others, Turkmenistan and Uzbekistan, the Programmes are expected to be approved shortly. The strategic planning process in Kazakhstan has been a special case. Although, unlike in the other four countries, no substantial revision of the pre-independence HIV policy has yet been made in

Kazakhstan, an important development was the formulation and formal approval of two important strategic documents, the National Healthy Lifestyle Development Strategy (HLDS) and the Integrated Programme of HLDS Implementation in the areas of reproductive health/family planning, HIV/AIDS, STD and drug abuse prevention. Both documents have placed HIV/AIDS, STD and drug demand/harm reduction higher on the country development agenda and opened up possibilities for comprehensive revision of relevant sub-sectoral policies in a broader and more integrated strategic context (Box 9).

Table 4.

Status of National Programmes development and approval

Country/Programme	Status
Tajikistan National Programme on HIV/AIDS and STD Prevention for 1997-2000	Approved by the Presidential decree in April 1997
Kyrgyzstan National Programme on HIV/AIDS and STD Prevention for 1997-2000	Approved by the Government decree in September 1997
Turkmenistan National Programme on HIV/AIDS and STD Prevention for 1998-2002	Under consideration at Prime Minister office since November 1997
Uzbekistan National Programme on HIV/AIDS and STD Prevention for 1999-2001	Being cleared by relevant ministries before going to the Cabinet of Ministers for approval
a) Kazakhstan National Healthy Lifestyle Development Strategy (HLDS) for 1998-2000 b) Kazakhstan Integrated Programme of HLDS Implementation in the areas of reproductive health/family planning, HIV/AIDS, STD and drug abuse prevention for 1998-2000	Approved by the Government decree in December 1998 Approved by the Government decree in December 1998

9. **ACHIEVEMENT BOX.** ***AVOIDING FRAGMENTATION OF HEALTH PROMOTION ACTION IN KAZAKHSTAN: INTEGRATION OF HIV, STD AND DRUG ABUSE PREVENTION TARGETS WITHIN HEALTHY LIFESTYLE DEVELOPMENT EFFORT AND BROADER SOCIAL DEVELOPMENT CONTEXT***

The health sector leadership in Kazakhstan has effectively built on the momentum created by an intensive strategic planning in the country for medium- and longer run and promoted HIV/AIDS, STD and drug abuse prevention priorities, as a cluster of inter-dependent targets, high on the health promotion agenda in a wider context of social development.

The beginning of a new phase of the nation development since late 1997, when the long-term National Strategy 'Kazakhstan 2030' was formally launched by the President as the overall strategic vision for the country for the next three decades, is marked with significantly more attention that the social needs of people start to attain in official plans, priorities and strategies. The social development chapter of the Strategy 2030 has stressed the human-centered development as the main underlying principle of country development, having set the target of combating absolute poverty and declared health, education and well-being of the citizens among top priorities.

The National Healthcare Reform Programme has been developed, as the mid-term sectoral strategy, within the framework of the national Strategy 2030 and officially launched in November 1998. The Programme has set the general directions for health reform that included, importantly, shift from curative services towards preventive medicine, promotion of primary care and decentralisation, strong focus on

9. **ACHIEVEMENT BOX.** ***CONTINUED***

international experts; one group concentrated on reproductive health and family planning and another one on HIV/AIDS, STD and drug demand/harm reduction. The most important feature of the Integrated National Programme is that it tackles the selected components in a coherent way through largely common approaches and interventions. The major integration tracks that the Programme takes include synchronised development of health promotion components of the sub-sectoral policies and coherent improvement of legislation and regulatory environment; joint technical capacity building of specialists; development and implementation of integrated IEC strategy and youth campaign; multi-focal pilot initiatives targeting vulnerable groups; and integration of sub-sectoral policies, along their preventive focus, into overall healthcare reform. The National Integrated Implementation Programme for selected components of the Healthy Lifestyle Development Strategy was formally approved by the Government on 14 December 1998.

The National Programmes of Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan, as the overarching frameworks for HIV/AIDS and STD prevention, all outline the key policy directions and priority interventions as grouped around the following key strategies:

- continuous formulation/refinement of relevant policies to underpin the programmes and improvement of legislation and regulatory environment
- prevention of sexual transmission of HIV and STD by promoting safe sex behaviour through mass communication, public information and school education as well as condom promotion and improvement of accessibility and quality of STD service
- blood safety and infection control assurance
- prevention of mother-to-child transmission
- provision of medical care and social support to affected people and their families
- establishment of a system for multi-sectoral cooperation with NGO participation, and ensuring the effective management, coordination, monitoring and evaluation of the programme implementation.

In Kazakhstan, while the substantial revision of HIV/AIDS policy is still at an early stage and being accelerated now by the enforcement of the Integrated Programme of Healthy Lifestyle Development (described above in Box 9), the new National Programme for STD Prevention and Control for 1998-2000 has been formulated and is seen to constitute a major break-through with regard to re-orientation of health services in Kazakhstan. The Programme sets the targets of decentralisation of the STD service, promotion of confidential one-stop service, gradual introduction of syndromic STD case management particularly at the primary healthcare level, step-wise expansion of out-patient service and significant strengthening the primary prevention of STD.

Although the National HIV/AIDS/STD Programmes in Central Asian states have been approved recently or still under consideration by top Government, their enforcement seem to advance gradually along key directions, and there examples already exist in the sub-region that illustrate how sound policy directions guide effective practical actions (Boxes 10, 11).

10. **ACHIEVEMENT BOX.** ***SCHOOL EDUCATION ON SAFE BEHAVIOUR IS EXPECTED TO TRANSLATE INTO LOWER RISK OF EXPOSURE TO HIV, STD AND DRUG ABUSE IN UZBEKISTAN***

School education sector in Uzbekistan introduced three modules in school curriculum that promote moral and family values and cover important issues of relevance for HIV/AIDS, STD and drug abuse prevention. Those are Culturology; Human Health; and Ethics and Psychology of Family Life. Innovative approach that the sector has taken was also establishment of a course for parents called ‘Parents Universities’ which provides for continuous dialogue between teachers and parents to reinforce their mutual efforts in promoting children’s safe behaviour.

The system of teachers retraining, which is a well-organised network of post-diploma institutions at central and local levels, has been promptly adapted to respond to the need of teaching new courses. Teachers’ skills are upgraded through post-diploma training either by 1 month refreshment course or 8-10 month retraining course. Starting 1996 a position of counselling specialist exists in all schools, and the respective training course functions in Universities.

Extracurricula activities such as sport and cultural events, summer camps etc. are viewed a powerful instrument for promoting proper behaviour and considered a responsibility of school education system.

This experience presents a notable example of how safe behaviour can be promoted in school

Given the fact that drug injecting drives HIV epidemics in some CIS countries including Kazakhstan, the drug demand aspects of national drug control programmes are worth mentioning in the HIV/AIDS-related context. Drug Control Master Plan in **Kyrgyzstan** for 1998-2000 has been approved by the Government in December 1997 and has drug abuse prevention among its five major strategies. The Master Plan in **Kazakhstan** for 1998-2005 is currently under consideration by the Government; it incorporates important elements of drug demand reduction including drug education among in-school and out-of-school youth; involvement of parents, teachers and community leaders into drug abuse prevention; multi-sectoral cooperation with the participation of law enforcement officials, media and other sectors in drug demand reduction; and introduction of relevant modules into school curricula. In **Turkmenistan** the State Drug Control Programme for 1998-2000 was adopted in May 1998 and sets, among the main targets, increase in public awareness about drug abuse through wide campaigns and improvement of treatment and rehabilitation service for drug addicts. The **Uzbekistan** National Programme on Drug Control has been recently drafted and circulated among relevant sectors for comments before it will go to the Cabinet of Ministers for approval. The Programme puts strong emphasis on drug abuse prevention and improvement of treatment and rehabilitation service for drug addicts. The Programme seeks to enable the comprehensive assessment of the magnitude of drug abuse problem, to streamline and significantly strengthen IEC activities that the National Drug Control Commission has already started to promote in cooperation with relevant sectors, and to promote progressive legislation on medical and social rehabilitation of drug addicts that would legitimate the anonymous service. In **Tajikistan**, despite the difficult internal situation, the Government has taken some steps to develop an anti-drug strategy. The new drug control plan includes addressing social problems that escalate drug abuse and improvement of treatment and rehabilitation service for drug users.

11. **ACHIEVEMENT BOX.** ***KYRGYZSTAN: NGO/GOVERNMENT PARTNERSHIP IN ACTION***

The concept of the promotion of NGO/Government cooperation in assisting vulnerable groups in Kyrgyzstan was turned into action with the strong support from the National Programme. The concept is based on the understanding of a need for NGOs and their partners from state services and institutions to come into practical partnership where all the parties have their specific roles to play in a complementary and mutually reinforcive manner. NGOs and CBOs facilitate people's access to the Government's preventive and care services and reinforce them with peer education. The state health services, through this partnership, become more aware of the importance of trusting relations with vulnerable groups and improve capacity to meet their particular needs.

Example 1: MSM NGO *OASIS.* A group of young MSM has been voluntarily cooperating with the National AIDS Center in Bishkek, Kyrgyzstan, since 1995. In 1997 the partnership has significantly strengthened when a group was registered as an NGO and engaged in some joint programmes with the Center. Among the recent joint activities there were the conduct of the KAPB survey among MSM and preparation and publication of twelve types of booklets on safe

2.4 LEGISLATIVE AND REGULATORY ENVIRONMENT

Most of Central Asian countries have made progressive steps towards improvement of legislation related to issues concerning case detection and confidentiality as well as dealing with vulnerable groups particularly MSM, CSW and injecting drug users.

Kyrgyzstan has taken the lead in the sub-region in revising and adopting the HIV/AIDS Law to make it more conducive for effective addressing HIV/STD problems. The new law was adopted by Parliament and approved by the President in December 1996. Revised AIDS Law in **Turkmenistan** has been cleared by the Government and submitted to Parliament. In **Uzbekistan** the revision of former HIV/AIDS law has been recently completed and the new draft is currently under consideration at the Cabinet of Ministers before it will go to Parliament. Revision of HIV/AIDS Law is underway in **Tajikistan** as initiated by the Ministry of Health with the involvement of specialists from the Ministry of Justice.

The revised AIDS laws provide for voluntary anonymous HIV testing with pre- and post-testing counselling, confidential testing in clinically suspected cases based on informed consent, full coverage of blood donors with confidential testing, and limits epidemiological control with sentinel serosurveillance. The laws stress the obligation of the states to ensure people's access to safe and confidential testing, information about HIV/AIDS prevention, means of protection, safe blood transfusion as well as to medical care and social support for people living with HIV/AIDS.

A tangible result of the process of critical reviewing and improvement of AIDS laws in some Central Asian countries has been downsizing the range of population groups to be

compulsory tested and, therefore, the drop in the numbers of mandatory tests performed. In Kyrgyzstan, following the adoption of the new law, in 1996 the number of people tested decreased by 1,7 folds compare to 1995 and by 4,4 folds compare to 1992. Two-fold decrease in the number of mandatory tests was also reported in Turkmenistan in 1996 and in Tajikistan in 1997. At the same time, mass screening policy appears to be still strong in Kazakhstan and Uzbekistan. The number of tests performed in Kazakhstan was fluctuating between 1,4 and 1,1 million annually over the period of 1994-1998. In Uzbekistan the number of performed compulsory tests has been maintained at the level over 1 million in 1995 and 1996 and was still as high as around 900,000 in 1997.

Pieces of legislation that deal with vulnerable groups show some progress in the countries of the sub-region. Homosexual relation is not considered any longer a criminal offence in some countries or the law against MSM is not enforced in practice in the others. There are no references to prostitutes or clients in any official laws; pimping and running brothels are illegal. Drug use as such, and the possession of small quantities of drugs are no longer punishable, while trafficking, the storage of drugs and the possession of more than minimal quantities remain illegal.

However, the system of regulations and instructions, particularly those that apply to HIV/AIDS, STD and drug addiction treatment services as well as to interior sector, determine existing practices that create barriers to effective preventive communication between care providers and clients from vulnerable groups. An example here is the consistent tightening of administrative and control measures in STD sector of Uzbekistan (Box 12).

Mandatory STD and HIV testing of MSM, women suspected in prostitution and IDU, accompanied by registration of these people with sharing this information between mentioned authorities, push vulnerable groups underground and put out of reach of potential interventions to reduce the risk of HIV and STD acquisition. The confinement of the majority of STD patients into in-patient clinics for compulsory treatment as well as forcible referral of identified drug users to confined centers for detoxification result in even stronger fear among these groups to deal with health services, impede building the trusting relations and, thus, hamper adequate outreach to these people.

At the same time, there also exists a positive experience in the sub-region when the legislation has been promptly amended in HIV outbreak site in Temirtau, Kazakhstan, to enable

12. **CHALLENGE BOX.** ***UZBEKISTAN: REGULATIONS PUT CONSTRAINTS ON STD CARE ACCEPTABILITY***

STD service leadership in Uzbekistan believes that it succeeded to mobilise more attention and support from the Government following its appeal to the Prime Minister in August 1995 when STD crisis became particularly apparent. Four consequent decrees were issued by the Government during 1995-1998 all requesting to significantly tighten the measures aimed at case detection, contact tracing and mandatory testing, and to ensure that STD treatment is provided only by STD specialists in categorical clinics. To this end, mobile investigation groups were set up and currently function, compulsory testing reinforced in all health care institutions, active involvement of police and other sectors requested for case investigation and confinement for treatment.

interventions among IDU
(Box 13).

13. **ACHIEVEMENT BOX.** ***LEGISLATION AMENDED IN TEMIRTAU, KAZAKHSTAN: WARNING SIGNALS AND A QUICK RESPONSE***

In 1997, as evidence of HIV outbreak among injecting drug users in Temirtau city (Kazakhstan) mounted, local authorities and the oblast Parliament reacted by creating, on a pilot scale, a legislative and regulatory environment that enabled intervention programme in a community, including the harm reduction component.

The decree issued by a city major and approved by the oblast Parliament in July 1997 declared the following principles of the preventive work among IDU: abolishment of repressive measures against IDU; reliance on voluntary and confidential approach in dealing with IDU on the side of health services; assistance to IDU in switching to less harmful ways of drug use; and active cooperation with IDU in the development and implementation of intervention programme.

Specific steps requested by local authorities and legislature included:

- introduce voluntary anonymous HIV testing of IDU
- consider legal the possession of up to 2 ml of opiate solution as well as used syringes and needles
- set up the local multi-sectoral coordination committee at major office backed up by technical advisory groups
- establish and equip four trust points for needle exchange and counselling.

2.5 PREVENTIVE APPROACHES IN COUNTRIES' RESPONSE

As described above in Sections 2.2-2.4, there are clear positive developments in Central Asian countries in setting sound preventive goals and coordination mechanisms in their programmes as well as in creating enabling legislative and regulatory environment for addressing HIV-related problems. This progress is becoming reflected in re-orientation of practical operation of health services and their cooperation with other governmental sectors and non-governmental partners. However, the current practices have not yet evolved into a consistent system of preventive actions. At the moment they still present a mixture of the approaches inherited from the past that gear towards restrictive and discriminatory measures with the newer ones that pave their ways to improve effectiveness, accessibility and acceptability of services and interventions and to promote preventive focus in the cross-sectoral cooperation.

Conditions are being created for the promotion of **voluntary anonymous HIV testing and counselling** in countries of the sub-region through the establishment of anonymous testing sites and training the staff of the service. Demand for anonymous testing started to emerge recently but is still very low: percentages of anonymously tested clients in 1998 have been as

small as about 1% in Uzbekistan, 1,2% in Kazakhstan, 1,6 % in Turkmenistan and 6.5% in Kyrgyzstan, out of the total numbers of tested people. Health sector and mass media need to play more active role in publicising new services and encouraging people to make use of them. It applies fully to the promotion of health care seeking behaviour for STD that has to keep in pace with STD service reform.

Improvement of **accessibility, acceptability and effectiveness of STD service** is an important priority of preventive strategies which is being increasingly recognised as a key principle of service re-orientation in Central Asian countries. Accomplishing this presents a challenge, given the existing structure of STD service as a highly verticalised network of specialised institutions and the regulatory environment that defines case investigation and confinement for treatment as main operational priorities of the service in most countries of the sub-region. However, understanding of a conflict between compulsory approaches and the need to build the trust in service among clients has motivated STD services across the sub-region to start introduction of ambulatory and confidential STD service, plan for the service decentralisation and its step-wise integration into general healthcare system, and initiate upgrading the operational standards, guidelines and procedures of the service to enable comprehensive STD case management (Box 14). This evolving strive marks important change in countries' response to STD epidemics but it needs to be sustained and significantly strengthened to cope with the problem of this unprecedented magnitude.

14. **ACHIEVEMENT BOX.** ***MOVE TOWARDS BETTER ACCESSIBILITY AND SUITABILITY OF STD SERVICE IN CENTRAL ASIA***

The principles of the revised STD policy in **Kazakhstan** has been approved by the Minister of Health in January 1998 to pursue the service decentralisation, confidentiality, introduction of ambulatory service, offer of treatment at the first point of contact with the health system, adopting syndromic management of STD, switch from contact tracing to partner notification, and strengthening the primary prevention of STD. Although funding of the new National STD Programme is pending, the programme enforcement has already began. Within 1998, the

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14. **ACHIEVEMENT BOX.** ***CONTINUED***

transition of STD sector to ambulatory service was completed nation-wide and applies now to all patients, with the exception for complicated cases of syphilis like meningitis or congenital syphilis. Observance of the principle of confidentiality in STD care was put into practice following the decision made at the national STD conference in September 1998. In pursuit of STD service decentralisation the authority to licence STD care providers was given to local health administrations. National Guidelines for syndromic management of STD cases were prepared, approved and enacted in early 1998. To ensure the adherence to quality standards of care and compliance with the revised guidelines and procedures a national plan for staff re-training was developed and operationalised. Thus far, two training workshops were held including a national one for chief doctors of STD clinics and WHO-assisted oblast-level ToT seminar for STD practitioners that educated a core group of trainers from Southern region of Kazakhstan for further 'cascade' training of their colleagues from STD sectors and other health care structures including first-level healthcare facilities, maternal and child health clinics and family planning clinics. The next workshops are planned to be organised in Central, Northern and Eastern regions of Kazakhstan. Counselling and condom distribution have been introduced across the service as primary prevention component along with syndromic case management. To match up with healthcare reform, the course on STD case management has been recently built into the family practitioner training curriculum of the National Postdiploma Training Institute for Health Professionals.

Central Asian countries see the emergence of **inter-sectoral practical partnerships**. This trend highlights an important **move from over-medicalised approach** to HIV/STD-related problems **towards multi-sectoral collaboration** where increasing number of sectors come into partnership based on the understanding that each of them has a stake in prevention. A notable positive example here is the promotion of safer sex behaviour and drug abuse prevention through **school education** in Kazakhstan (Box 15).

Social mobilisation via **mass communication and public information** has not yet evolved into a broad-based concerted effort but the practical dialogue of health and information specialists and media professionals is advancing with different speed in countries of the sub-region with strong support from UNAIDS and its co-sponsors, as can be seen by well-progressing multi-media campaign in Kyrgyzstan (Box 16). Development and implementation of a district-level IEC strategy in Temirtau, Kazakhstan, with the assistance from inter-agency UN project is another good example of introducing a sound IEC approach that seeks to promote cross-sectoral planning and develop common understanding of issues and methodologies of preventive communication by health professionals and journalists through joint capacity building.

15. **ACHIEVEMENT BOX.** ***PARTNERSHIPS IN PREVENTIVE SCHOOL EDUCATION EXPAND IN KAZAKHSTAN***

Several initiatives have been undertaken in developing preventive education curriculum in Kazakhstan of which two have resulted in the introduction of new modules embracing the issues of high relevance for HIV/AIDS, STD and drug abuse prevention. This accomplishment was made despite the fact that the school curriculum is pressed and there were many issues competing for space. The reason for success has been largely the participatory inter-sectoral approach that contributed to both the broader forum for discussion of curriculum content and more effective advocacy for new curricula approval.

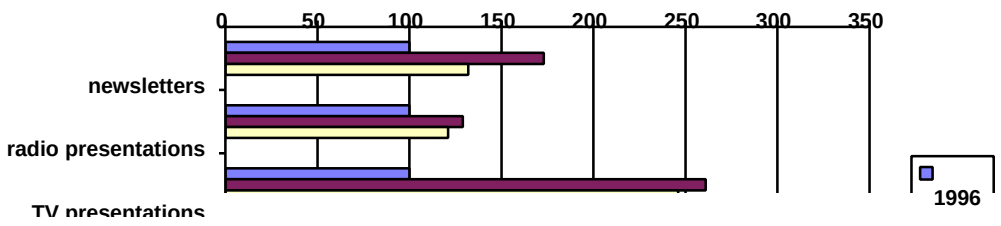
An NGO *Kazakhstani Medical and Pedagogical Association* has taken the lead in the development of the **school curriculum on moral and sex education.** Association has been set up in 1996 to consolidate the efforts of health professionals, school and university teachers, journalists and youth leaders in promoting sex education among youth. The Association conducted the survey among school students to analyse the sources of information about risks associated with unprotected sex and identify the gaps in knowledge. Based on the survey findings, curriculum for grades I through XII and instructional manual for teachers were developed, with the support from UK Know How Fund, and recently approved by the Ministry of Education, Culture and Health for introduction in school education system.

Alongside the curriculum and instruction material development, Association built the capacity of the core group of trainers from among doctors, paramedics and medical students who then

16. **ACHIEVEMENT BOX.** ***PREVENTIVE COMMUNICATION IN KYRGYZSTAN AND KAZAKHSTAN GAINS STRENGTH THROUGH HIGHER COMMITMENT OF EDUCATORS AND BETTER FOCUSING ON COMMUNITY NEEDS***

Leadership of the national AIDS service in **Kyrgyzstan** believes that advocacy and awareness creation foci of UN-assisted projects strongly motivated health professionals and media specialists to multiply their efforts on public information and mass communication (Fig. 16). Following the operationalisation of two UN-assisted projects in 1996 and in 1997, the number of IEC activities increased significantly in 1997 and was retained close to that level in 1998 in spite of financial constraints that the relevant sectors face. Notable trend has also been growth in a number of sociological studies conducted for audience research and better targeting of information campaigns.

Fig. 16. Public information and mass communication activities on HIV/AIDS prevention in Kyrgyzstan over 1996-98, percentages (1996=100%)



Cooperation with the interior sector needs significant strengthening and remains a priority need in the sub-region. This is particularly the case for penitentiary system in Kazakhstan where the problem of HIV infection in prisons aggravates dramatically while not being properly addressed by prison administrations (Box 17).

17. **CHALLENGE BOX.** ***KAZAKHSTAN: HIV, STD, TUBERCULOSIS AND INJECTED DRUG USE IN PRISONS - A CAUSE FOR MAJOR CONCERN***

Kazakhstan has one of the highest ratios of prisoners to population in the world (448 imprisoned per 100,000 population), with the total number of prisoners about 77,000, as of early 1997. A standard of living in prisons, status of nourishment and health and work availability were adversely affected by the difficult economic transition in Kazakhstan and remain grossly inadequate. Only about 30% of prisoners have work (compare to 70% in the pre-independence times), approximately 2000 prisoners die from diseases annually. Around 16,000 prisoners (or almost one out of five incarcerated people) suffer from some form of tuberculosis; 10,000 of them suffer from the active form of TB. Tuberculosis was a cause of death in 1,300 out of 2,000 deaths in prisons registered in 1995. Situation with STD is also dramatic, as was shown by the study the National STD Center conducted in one of the penitentiary institutions near the capital in 1997 when syphilis was found in 10% of tested prisoners, compare to syphilis incidence of 0,4% among urban residents. HIV infection in prisons poses an increasing threat of rapid spread: at present, 20% of HIV-infected people are incarcerated with the total number of 143 seropositive prisoners.

There is a growing understanding in the sub-region that **community involvement and NGO development** have to become essential components of the response to HIV, STD and drug abuse problems, especially in targeting vulnerable population groups with focused interventions. This constitutes an important breakthrough, given that voluntary action and the formation of NGOs are, in general, new phenomena in Central Asia and that hostile attitudes towards vulnerable groups (MSM, CSW and IDU) prevailed in the past and still are notable in stigmatising practices of police and health services. Some Central Asian countries already see the appearance of NGOs that have a potential to initiate and sustain preventive dialogue with their communities based on the trust among target populations and ability to rapidly develop organisational and technical skills, as was shown by a number of UN-assisted NGO initiatives in Kazakhstan (Box 18).

18. **ACHIEVEMENT BOX.** ***ACCESS TO THE AFFECTED AND VULNERABLE COMMUNITIES IS SEEN A PRIMARY NEED BY THE UN-ASSISTED PROGRAMME IN TEMIRTAU, KAZAKHSTAN***

The thrust of the community involvement effort within the UN-supported project in Temirtau, the site of HIV outbreak among IDU, was understanding achieved by local authorities and other partners that access to the affected and vulnerable communities and the trust of these marginalized groups was only going to be achieved by nurturing and maintaining a relationship with NGOs formed from within those communities.

By now a number of NGOs have emerged in Temirtau and received training and start-up financial support including MSM NGO *Zhemchuzhina*, NGO *Antinar* working with IDU, NGO *Mothers Against Drugs* and NGO of people living with HIV/AIDS *Shapagat*. Importantly, NGOs were invited for active partnership in the coordination committee and enjoy support from local authorities ranging from facilitated registration of NGOs to provision of free premises and phone lines (MSM NGO). The range of activities that NGOs embarked and progress on include social

Emergence of positive experiences in **mobilising youth**, as both the target vulnerable group and active ally, into HIV/STD and drug abuse prevention is another important development in the sub-region (Box 19). In view of the young age structure of Central Asian populations the potential impact of youth participation is very high, depending on whether the successful approaches are closely monitored and timely scaled up.

19. **ACHIEVEMENT BOX.** ***YOUTH MOBILISATION IN UZBEKISTAN: NEW AGENDA IS UNDER FORMATION***

National Youth League KAMOLOT has been established in Uzbekistan as a country-wide youth movement and enjoys strong support from the Government. The collapse of the Soviet system created a spiritual vacuum as the ideological framework within which the society had functioned was suddenly invalidated. The Communist morality that used to be promoted by *Komsomol* youth organisation in the former USSR has been largely negated by the collapse of the ideology. The loss of moral direction among youth has become a major concern for the Government. In the circumstances, Youth League KAMOLOT seeks to give a sense of direction to young people by promoting the traditional values of Uzbek society including respect for family and the all-embracing sense of community.

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19. **ACHIEVEMENT BOX.** ***CONTINUED***

Notably, health promotion has already become an important direction of League's activities including sport and cultural events and information campaigns. Given that the organisation has 228 affiliations at the local level and own printed media (4 newspapers and 3 magazines), the potential of the League to become a key player in mobilisation of youth against HIV/AIDS and drugs is high. The League cooperates with STD service on pre-marriage counselling. Another counterpart of the League is the National Drug Control Commission with which it collaborates in the assessment of the level of awareness about drugs and drug addiction among schoolchildren and university students. The League's plans for future activities, to be supported by UN-assisted project, include further improvement of the capacity to deliver preventive messages through information campaigning as well as youth competitions, contests, shows, festivals etc. The League is centrally-placed also for the promotion of peer education. Towards this end, it is envisaged that a core group of youth leaders from League's branches in the Universities will be trained as a multi-disciplinary team of medical, educational and journalism students to further act as trainers for youth peer educators at the local level.

Until recently, with health services' preoccupation with the control measures and reliance on testing/diagnosis as a means to examine the magnitude of the problem, the need for effective monitoring of awareness level and behaviour change for programme development and evaluation did not appear straightforward. However, while the importance of prevention rather than surveillance and control has been increasingly recognised, the need in behavioural information becomes apparent. Though, in general, the capacity to assess the knowledge and behaviour change is still rather weak in the sub-region, increasing efforts are being made to collect the information through **social and behavioural studies** and to use it as a tool for programme development (Box 20).

20. **ACHIEVEMENT BOX.** ***NEED IN THE ASSESSMENT OF BEHAVIOURAL RISK AND KNOWLEDGE GAPS IS FELT IN KAZAKHSTAN***

The behavioural survey was conducted in **Kazakhstan** by the National STD Center in collaboration with the leading sociological agency Giller Institute among in-school teenagers of 15-17 y.o. and teachers in 1997 with the view to assess sexual behaviour of young people and their knowledge of risks associated with STD and HIV/AIDS. The findings and conclusions of the survey have been discussed at the national conference organised by the National STD Center in 1997 that brought together health officials, STD practitioners, teachers from different oblasts and NGO representatives. The recommendations produced by the conference boosted the work on sex education curricula development and promoted the recognition of primary prevention of STD as an essential component of effective STD control. Among important observations made through the survey has been high risk posed by unprotected sex in young people: 9% of sexually active respondents have already suffered STD but vast majority of them have chosen self-treatment or approaching unlicensed practitioners. A warning signal has also been the clear indication of high potential for prostitution among adolescent girls: 40% of responded sexually active girls reported that they received or receive remuneration for sexual intercourse. Findings of the survey among teachers showed that their knowledge of risks associated with STD and HIV transmission is sub-optimal and that, alarmingly, one third of teachers have harsh attitudes towards STD patients and HIV-infected people.

PRINCIPLES FOR UPGRADED AGENDA

Response to HIV/AIDS, STD and drug use problems in Central Asia has significantly advanced over the span of last three years and is characterised now by a new level of understanding by Governments, NGOs and other national partners of the threat posed by these problems. This understanding is marked with considerably more attention that the preventive targets start to attain in official plans and policies, as well as with positive developments in legislative and regulatory environment for addressing HIV-related problems. The need for collaboration to cut across the sectors and to enable productive dialogue between central and local levels is recognised to far more extent, and mechanisms for coordination are being put in place. This progress becomes increasingly reflected in re-orientation of practical actions. At the same time, the overall preparedness of countries to effectively confront HIV/AIDS or cope with STD and drug abuse spread remains sub-optimal. Given the continuing socio-economic difficulties of transition period, changes in

lifestyles and existing gaps in skills and capacity for adequate preventive work, the challenge now is to build further on what has been successfully started, improve quality and sustain impact.

To a certain extent, the positive trends in countries' response are attributable to the development assistance catalysed by UNAIDS and supported by co-sponsors and other donor partners. Collaboration was progressing through a phased approach and laid solid grounds for expanded response including higher commitment and motivation of leadership and strengthened technical capacity of those involved in practical preventive work. Cooperation programmes and projects, though progressing in Central Asian countries with different speed and at different scale, give opportunities to test and adjust concepts and approaches and, thus, to form a body of knowledge and experience in countries and the sub-region adapted to local realities. Partnerships within the development community have also formed and strengthened. The new and more advanced stage of UNAIDS-assisted cooperation calls for upgraded agenda for the sub-regional strategy. Its guiding principles are:

- *to follow further a phased approach at the sub-regional, national and local levels*, where foundations for expanded response laid through political commitment and strengthened capacity serve the basis for improving policies and legislation and help to translate them into impact-oriented actions; phasing and pace of progressing can be defined more clearly now for each country and supported with better targeted assistance through national and local-level programmes and projects;

- *to promote national ownership and responsibility over cooperation programmes*: it is an opportune time now to build on the achievements made by countries in formulation and adoption of sound strategies and policies so that the assistance be aimed at supporting progressive national strategic approaches while piloting with smaller scale interventions in the areas where acceptance remains a problem; enhancement of national execution by co-sponsors involved in administrative support is another essential tool to strengthen national ownership and thus sustainability;

- *to broaden resource and support base for assistance* by mobilising more active participation of UNAIDS co-sponsors and forming expanded partnerships and alliances with the participation of wider range of UN organisations, bi- and multi-lateral donors, international NGOs and private business sector; experience in partnership building and resource mobilisation that proved successful in the sub-region needs to be replicated and multiplied;

- *to increase reliance on the improved national and sub-regional technical expertise* and to strengthen liaison within CIS and CCEE regions for information and experience exchange and forming a network of opinion leaders to facilitate inter-country dialogue.

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